PRINTED: 02/15/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
			A. BUILDING 00			COMPLETED		
155241			B. WIN			01/30/2	2013	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
FOREST CREEK VILLAGE			525 E THOMPSON RD INDIANAPOLIS, IN 46227					
(X4) ID	IDENTIFICATION NUMBER: 155241 IAME OF PROVIDER OR SUPPLIER FOREST CREEK VILLAGE KA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for Investigation of Complaints IN00122808, IN00123246, and IN00122625. Complaint IN00122625 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00122808 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282. Complaint IN00123246 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282. Survey dates: January 24, 28, 29, & 30, 2013 Facility number: 000145				PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
F0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!		DATE	
1 0000								
	This visit was for Investigation of		F00	00				
	Complaints IN001	22808,						
	IN00123246, and	IN00122625.						
	Complaint IN0012	22625 -						
	Substantiated. No	o deficiencies						
	related to the alleg	gations are cited.						
	Substantiated. Federal/state							
	deficiencies related to the allegations							
	are cited at F282.							
	Complaint IN00123246 -							
	Substantiated. Federal/state							
	deficiencies related to the allegations							
	are cited at F282.							
	Survev dates:							
	0.00.00.00.00.00.00.00.00.00.00.00.00.0							
	Facility number: 000145							
	Provider number: 155241							
	AIM number: 100	275110						
	Survey team:							
	Diana Zgonc, RN-	-TC						
	Census bed type:							
	SNF: 19							
					l			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000145

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION OO			(X3) DATE SURVEY COMPLETED		
		155241		LDING		01/30/		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	0 17 0 01		
NAME OF PROVIDER OR SUPPLIER					HOMPSON RD			
FOREST CREEK VILLAGE					APOLIS, IN 46227			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG		LSC IDENTIFTING INFORMATION)		IAG	BH ICE. C. I		DATE	
	SNF/NF: 99							
	Total: 118							
	Conque nover typ	٥٠						
	Census payor type	⊌.						
	Medicare: 21							
	Medicaid: 73							
	Other: 24							
	Total: 118							
	Sample: 10							
	This deficiency reflects state findings cited in accordance with 410 IAC							
	16.2.							
	Quality Review co	ompleted on						
	February 01, 2013	3; by Kimberly						
	Perigo, RN.							
	-							

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	a. Building 00		COMPLETED		
155241		B. WIN			01/30/	2013	
NAME OF B	DROWDED OD CUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				525 E T	HOMPSON RD		
FOREST CREEK VILLAGE				INDIANAPOLIS, IN 46227			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0282	483.20(k)(3)(ii)	LSC IDENTIFYING INFORMATION)	+	TAG	Dia teliate i y		DATE
SS=D		UALIFIED PERSONS/PER					
	CARE PLAN						
		vided or arranged by the					
		rovided by qualified dance with each resident's					
	written plan of ca						
	Based on observa	ation, record review	F02	82	F 282 We respectfully request	for	02/06/2013
	and interview the	facility failed to			a desk review for F282. 1.Resident B's tray was audite	∍d	
	ensure physician's	s dietary orders			by the RD to assure all physic		
	were followed for	1 of 3 residents			ordered supplements were on tray for the next meal. No issu		
	reviewed for dieta	reviewed for dietary orders (Resident B).			were found. Residents B tray		
	B).				card was updated on 1/28/13 t		
					refelect on physicians orders. 2. No other residents were affected,		
	Findings include:				RD audited all residents trays		
		-		tray cards to ensure trays			
	The record for Re	sident B was		received all items as Dietary staff were in-			
	reviewed on 1/24/	13 at 1:20 P M			following diet cards by the RD		
	Teviewed Off 1/24/13 at 1.20 F.IVI.				The RD/designee is monitoring all		
	Diagnoses for Reg	viagnoses for Resident B included			resident trays for accuracy 3 times a day until 100% is met.		
	but were not limited to Alzheimer's			Nursing will continue to give			
		state of ill health,			dietary all physician orders and RD will update all resident tray		
	i i	wasting], and failure			cards. 4. To ensure compliand	ce,	
	to thrive. Resider				RD is using a CQI tool to monitrays and tray cards for	itor	
	hospice patient.				accuracy. If threshold of 95% i	s	
	Tage patient				not achieved an action plan wi		
	A current physicia	an's order originally			be developed to ensure compliance. RD will report		
					monthly to the CQI committee	,	
	dated 1/19/12, indicated to provide 120 cc (cubic centimeters) of				ongoing.		
	cranberry juice 3 t	•					
	meals.	amos a day war					
		nla ardar ariginalli					
A current physicia		in's order originally					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155241		A. BUILDING 00			COMPLETED 01/30/2013		
100241			B. WING	CED FIG. 4	DDDDGG GUTY GTATE GID GODE	01/30/.	2013
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE HOMPSON RD		
FOREST	CREEK VILLAGE				APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		cated to provide ice					
	cream with lunch	and supper daily.					
	A physician's telep	phone order dated					
	1/21/12 (sic) and	signed 1/22/13,					
	A physician's telephone order dated 1/21/12 (sic) and signed 1/22/13, indicated to include super yogurt with breakfast and dinner. During observation of the lunch meal on 1/28/13 at 1:10 P.M., Resident B was being fed by RN #1 in the main dining room. The resident's meal ticket on the table did not indicate the						
	breakfast and dinr	ner.					
	During observation	n of the lunch meal					
	on 1/28/13 at 1:10	P.M., Resident B					
	was being fed by l	RN #1 in the main					
	dining room. The	resident's meal					
	ticket on the table did not indicate the						
	cranberry juice, ic	e cream or super					
	yogurt as ordered	by the physician.					
	Observation of the	e resident's meal					
	tray verified the cr	anberry juice, ice					
	cream and super	yogurt were not					
	provided to the res	sident. During an					
	interview, at that t	ime with RN #1, she					
	indicated she had	not fed the resident					
	any cranberry juic	e, ice cream nor					
	super yogurt.						
	During an intervie	w with the Dietary					
	Manger on 1/28/1	3 at 1:40 P.M., she					
	indicated there ha	d been an audit of					
	the dietary orders	and had tried to					
	correct all meal tic	ckets. The resident					
	should have recei	ved cranberry juice,					
	ice cream, and su	per yogurt for lunch.					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155241		(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	COMPLETED 01/30/2013		
	PROVIDER OR SUPPLIE		STREET A 525 E T	ADDRESS, CITY, STATE, ZIP THOMPSON RD APOLIS, IN 46227	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
	This Federal tag Complaints IN00 IN00123246.						
	3.1-35(g)(2)						

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